

## Treatment Outcome Measurement

Choosing an appropriate means of measuring the effectiveness of the SAFE Program was challenging. Similar programs have used a variety of different instruments to assess treatment outcome, including measures focusing on consumer variables and family variables. Many projects have incorporated multiple outcome measures. There is not a consensus regarding what variables are important to assess, and an instrument has yet to emerge as the accepted standard. Few psychometrically sound measures of coping behaviors, self-efficacy, or caregiving created specifically for family members exist (Schene et al., 1998; Solomon, 1996). Most measures are based on the concept of caregiver “burden,” a construct that is difficult to operationalize (Schene, Tessler, & Gamache, 1994). Further research is needed to clarify these assessment issues and enhance our ability to measure efficacy of family education and psychoeducational programs.

Across different programs, the variables chosen to assess changes in family functioning have been quite diverse. Some variables measured with family members have included:

1. Knowledge of mental illness
2. Level of expressed emotion in the family
3. Attitude toward mental illness
4. Attitude toward the consumer
5. Level of overall psychological distress of family member
6. Level of depression in family member
7. Level of anxiety in family member
8. Psychosomatic symptoms in family members
9. Level of caregiver burnout
10. Level of subjective burden on family member
11. Level of objective burden on family member
12. Additional financial burden on the family
13. Family member’s embarrassment
14. Consequences for the children and family
15. Family coping abilities
16. Grief/loss
17. Self-efficacy
18. Positive aspects of the family member’s role, including “rewarding personal experiences” and “good aspects of the relationship with the consumer”

[Table One](#) reviews specific measures that have been used to assess each of these variables. Other research projects that have used the measures are also listed. A recent excellent summary of outcome domains and assessment measures for family education and psychoeducation is also available (Cohen, Glynn, Murray-Swank, et al., 2008).

Summarizing the results of the numerous studies of family interventions is quite difficult. The diversity of programs, differing mental illnesses included in the projects, small sample sizes in many studies, and use of different outcome variables across projects render adequate comparisons difficult. Many studies also lack long-term follow-up data, so longitudinal research is badly needed in this area. Further, consumer variables (e.g., current functioning level, chronicity of the illness, gender, culture) likely interact with the ability of the family program to produce positive changes (Kazarian & Vanderheyden, 1992). For recent reviews of research on family interventions, please see McFarlane, 2002; Pfammatter, Junghan & Brenner, 2006; Pharaoh, Mari, Rathbone, & Wong, 2006.

None of the existing measures adequately and concisely addresses the goals that had been established for the SAFE Program ([see p. 5 for review of goals](#)). Consequently, a new measure, the [SAFE Program Background Information Form \(Handout II\)](#), p. 213), was developed. All participants complete this measure at the beginning of every workshop.

Demographic variables measured include consumer diagnosis, duration of consumer's mental illness, relationship to the consumer, number of sessions attended, and amount of contact with the consumer.

As shown in [Table Two](#), the most common consumer diagnosis has been PTSD, with over half of veterans having this diagnosis. About one in five families had a veteran living with major depression. The length of time that the individuals had been dealing with the mental illness was variable, ranging from a few weeks to over 30 years.

Over half the participants reported extensive (24-hours/day) contact with the consumer, which is consistent with the fact that almost half the participants were wives. Almost one third had either moderate (daily) or minimal (once every few days) contact.

As indicated, participants have been predominantly (80%) women and have included the roles of wife, girlfriend, mother, child, sibling, husband, friend, and others (e.g., grandparent, chaplain, sister-in-law, and daughter-in-law). In contrast to many similar family education programs through NAMI or other family organizations (e.g., Schene et al., 1998) in which a large majority of participants are parents, almost half of SAFE Program participants were spouses. This difference is likely due to the older age of the veteran population, which implicates less involvement by parents and a greater role for spouses and children. Over one quarter of participants were in their 60s or 70s, and one third were in their 50s.

In addition to demographics, the SAFE Program Background Information Form also assesses the following variables:

### Consumer's Behavior:

- Medication compliance in past 3 months
- Number of psychiatric admissions in past 2 years
- Percentage of mental health appointments consumer has attended in past 2 years

### Family Member's Experiences in Past 30 Days:

- Level of self-efficacy in caring for consumer
- Level of distress
- Knowledge of loved one's mental illness
- Awareness of VA Medical Center resources
- Ability to engage in self-care activities

Preliminary evaluation of data collected in the first 3 years of the SAFE Program at the Oklahoma City VA Medical Center showed that program attendance was related to increased understanding of mental illness and enhanced awareness of VA resources. Workshop attendance is positively correlated with improvements in participants' self-care (Sherman, 2003). Evaluation of 5-year data found that program attendance was positively correlated with understanding of mental illness, awareness of VA resources, and ability to engage in self-care activities – and inversely correlated with caregiver distress (Sherman, 2006).

### Contact Information:

Michelle D. Sherman, Ph.D.

Email: [MichelleDSherman2@gmail.com](mailto:MichelleDSherman2@gmail.com)